LONG TERM CARE INSURANCE

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INTRODUCTION

For most consumers, the purchase of a long term care insurance policy requires long, hard thought. Policies are difficult to understand because they contain confusing phrases, and they vary widely on benefits and costs. The purchase of a long term care policy can also become an emotional decision when we think about our inability to take care of ourselves in the future.

This guide provides financial facts you need to get around these obstacles and make a wise decision for you and your family.

This guide, from the Missouri Department of Insurance outlines what long term care insurance is, who needs it, how you pay for it, what should be included in coverage and how to compare policies.

If you have questions after reading this brochure, you are welcome to contact the Missouri Department of Insurance.

MISSOURI DEPARTMENT OF INSURANCE OFFICE LOCATIONS

Consumer Hotline Number
(800) 726-7390

Jefferson City
Consumer Affairs Division
Room 830, Truman Building
Jefferson City, Missouri 65101
(573) 751-2640

Kansas City
615 E. 13th St., Suite 510
Kansas City, Missouri 64106-2829
(816) 889-2381

St. Louis
Wainwright Building
111 North 7th St., Suite 229
St. Louis, Missouri 63101-2176
(314) 340-6830

Telecommunications Device for the Deaf
(573) 526-4536

Do You Need Long Term Care Insurance?

Maybe. Maybe not.

It is difficult to predict who will need care over a long period of time. Much depends on your age and your health. Whether you should buy an insurance policy to cover long term care may also depend upon your finances. It doesn't make sense to buy something you can't afford.

We suggest you read this brochure and then talk with family members before making a decision.

What Is Long Term Care?

Long term care is the kind of help you may need if you are unable to take care of yourself because of a prolonged illness or disability.

Traditionally, long term care has been offered in nursing homes. Three levels of care are available in nursing facilities: skilled nursing care, intermediate nursing care and residential care.

Skilled Care is the highest level of care provided in nursing homes. Skilled care is given for medical conditions that require care by skilled medical personnel, such as registered nurses or professional therapists. This care, available 24 hours a day, is ordered by a doctor. Some patients require skilled care for a short time after an acute illness. Medicare and Medicaid will only pay for care in skilled nursing facilities.

Intermediate Nursing Care is for patients who require daily medical supervision, but not 24-hour care. The care is supervised by registered nurses and ordered by a doctor. However, the patients are usually in stable condition, and fewer procedures are required.

Residential Care is for patients who need assistance with daily living activities such as eating and dressing. The care can be provided by staff without medical skills.

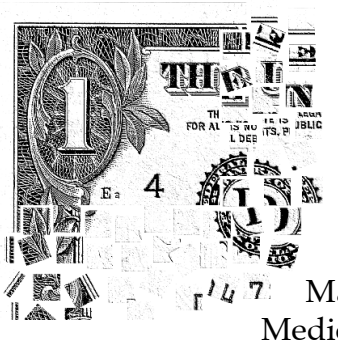
Alternatives to these three types of traditional nursing care are also available depending upon where you live.

Home Health Care is assistance provided in a home for ill, disabled or infirm people. It includes both nonmedical and medical services, such as:

- Assistance with daily living activities, like bathing and eating.
- Homemaker services like cooking and cleaning.
- Respite care to relieve caregivers by giving them a break from the daily duties for a loved one.
- Medical services like part-time skilled nursing care, special therapy and physical or occupational therapy.

Adult Day Care is a social and health related program provided in a group setting within the community.

It's very important to note that policies in Missouri must cover skilled, intermediate and residential nursing care. But, **a long term care insurance policy may or may not cover home health, adult day care and other alternative services**. Your policy may also require you to receive care in a facility licensed as a skilled care or intermediate care provider. You need to ask questions and carefully compare prospective policies.



WHO PAYS FOR LONG TERM CARE?

Many people assume that Medicare will pay if they need long term care. No, Medicare only pays limited benefits for short-term stays.

Many people assume their private Medicare supplement insurance, or Medigap policy, will pay for long term care expenses.

This is not the case.

Medigap is designed to pick up the portion of medical costs not paid for by Medicare, such as hospital deductibles or physician co-payments.

Many people assume that the health insurance they have through their employer will pay for long term care. Although more employers are beginning to offer this benefit, it's not widespread.

SO WHO PAYS? YOU DO.

Or in many cases, MEDICAID does, if you qualify for government assistance after spending most of your assets on nursing care.

Let's look at who pays for nursing care in more detail.

MEDICARE PAYMENT FOR NURSING HOME CARE

1. You must have been in a hospital at least three consecutive days, not including the day of discharge, before entering a nursing facility.
2. You must receive care in a SKILLED nursing facility.
3. Your doctor must certify that the care you need and receive is skilled nursing care or skilled rehabilitation care.
4. Your admission must be for the same condition for which you were treated in the hospital.
5. The nursing care must be received within 30 days of your discharge.

If you meet all of these conditions, Medicare pays for the following:

1. For the first 20 days, all covered expenses are paid by Medicare.
2. For the next 80 days, all covered expenses are paid by Medicare with a contribution from you.
3. Beginning on the 101st day, you are responsible for all charges.

MEDIGAP PAYMENT FOR NURSING HOME CARE

You can purchase a Medigap policy that covers your share of the costs between the 21st and 100th day.

MEDICARE AND HOME HEALTH CARE

Medicare pays for the full cost of medically necessary home health visits if you are homebound. Coverage includes:

1. The services of a part-time skilled nurse.
2. The services of physical and speech therapists furnished by a Medicare certified home health agency.
3. Other services such as home health aide services, occupational therapy, medical social services, and medical supplies, if ordered by your doctor.
4. Payment of 80 percent of the approved amount for durable medical equipment; you or your Medigap plan pay 20 percent of the approved amount.

Medicare does not cover:

1. Full time nursing care.
2. Drugs or meals delivered to your home.
3. Home services that primarily assist you in meeting personal care or housekeeping needs.

MEDIGAP AND HOME HEALTH CARE

Some MEDIGAP insurance policies offer an enhancement of home health services provided through Medicare. The policies pay for additional home health visits that are provided on a short-term basis. The visits may be used for assistance with daily living activities if you are recovering from an illness, injury or surgery.

NOTE:

Insurance agents are required by state law to supply prospective clients who are interested in Medigap policies a copy of the brochure *Guide to Health Insurance for People with Medicare* or another guide that complies with state law. It outlines the coverage available in a Medigap policy.

You may request a free copy of that brochure. It was developed by the Health Care Financing Administration of the U.S. Department of Health and Human Services, and the National Association of Insurance Commissioners. The publication number is HCFA-02110.

To request a brochure, contact:

Department of Health and Human Services
Health Care Financing Administration
6325 Security Boulevard
Baltimore, Maryland 21207

Or you may obtain the publication by contacting the Missouri Department of Insurance (see page 3) or CLAIM (see page 18).

MEDICAID

Many people who begin paying for nursing home care out of their own pocket often turn to Medicaid for assistance because they become impoverished.

You may have heard that Medicaid helps people with their nursing home bills after they "spend down" their assets. You may wonder: what exactly does that mean?

MEDICAID AND NURSING HOME CARE

To qualify for Medicaid, a caseworker with the Division of Family Services will conduct an investigation when you apply. The caseworker will have you list all of your available resources.

If you are single, to qualify for Medicaid, you have to "spend down" (spend your own resources on nursing care) until your assets are less than $1,000. You can keep your house, personal property and car. You may also keep $30 a month for personal

needs and the amount you need to pay for health insurance.

If you are married, you can divide some assets so your spouse is protected. This assessment is done during the month when you or your spouse enters the nursing home or applies for assistance. The maximum amount your spouse may keep is one-half of a couple's assets up to $68,700, but not less than $13,740. (For example, if you have assets of $150,000 the most your spouse would be able to keep is $68,700. However, if you have assets of $12,000, your spouse would be able to keep the entire amount.) You are allowed to keep your house, personal property and car.

If you have transferred assets in recent years, before seeking government assistance, the transfer may count in deciding your eligibility for nursing care benefits. If you have questions about Medicaid eligibility, you may wish to consult with an attorney.

Medicaid and Home Health Care

If you qualify for Medicaid, you may be eligible for up to 100 home health visits a year. Other services provided through Medicaid include personal care, adult day care, visits by physicians, emergency ambulance service, oxygen and prescription drugs.

More Information

This is not the full story on Medicaid.

For more information, contact the Division of Family Services office in your county.

You may also want to request two pamphlets about the Medicaid program.

They are "Medicaid and You" and "What You Should Know About Medicaid Payment for Nursing Home Care." These publications are available through your county Family Services office or by contacting:

Missouri Department of Social Services
Division of Family Services
Information and Correspondence Unit
P.O. Box 88
Jefferson City, MO 65103
Toll free phone (800) 392-1261

Insurance Policies Available

Long term care insurance is designed to offer a degree of security at a reasonable cost to offset the unknown risk of a greater expense.

There are three types of policies offered: indemnity policies, expense policies, and life insurance policies with a rider for long term care.

Indemnity Policies

Most policies are "indemnity" policies. That means the policy pays a fixed dollar amount for each day you receive care in a nursing facility or in your home.

Before making a decision about how much you want your policy to reimburse, you need to check the nursing homes in your community and see how much they cost.

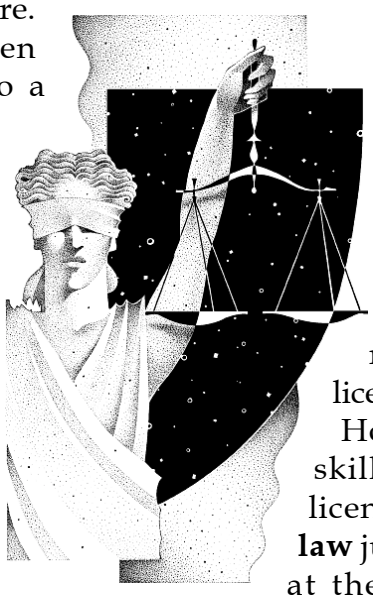
Because medical costs keep going up no matter where you live, Missouri now requires insurance companies to offer you a policy containing an optional inflation adjustment. There will be more information about that option later in this brochure.

Expense Policies

Expense policies pay the actual expenses incurred; a set percentage of the expenses incurred; or up to a maximum dollar amount per day.

Life Insurance Policies

Some life insurance policies offer long term care benefits. Under these "living benefits" provisions, or riders, a portion of the life insurance benefit is paid to the policyholder if long term care is needed—rather than to the beneficiary at the time of the policyholder's death. The death benefit under the life insurance policy will then be reduced by the amount paid for long term care. Benefits for long term care are often limited by the rider and policy to a percentage of the total death benefit.



What Type of Care Does the Policy Cover?

Most long term health care policies offer coverage for three levels of care: skilled, intermediate, and residential. Many policies also offer home health care and adult day care.

Missouri law provides that your policy can not pay just for skilled care, or more for skilled care than other types of coverage. However, your policy may require you ro receive care in a facility licensed as a skilled care or intermediate care provider.

Prior Levels of Care

Missouri law states that you do not need a prior hospital stay before becoming eligible for nursing home benefits from your long term care policy. (On the other hand, Medicare does require hospitalization before reimbursing for skilled nursing care.)

But, under **Missouri law**, your policy can require prior confinement, either in a nursing home or a hospital, before it will pay for home health care. The company can not require that you use adult day care or some other type of community program before you are eligible for home health care benefits.

Be sure to ask the agent what type of restrictions are in the policy and must be met before benefits will be paid.

Location of Treatment

Your long term care policy must allow you flexibility. It can not specify places of treatment.

In Missouri, long term nursing care is only available in facilities licensed by the state as skilled or intermediate nursing facilities. This means your insurance company will only reimburse you if you stay in a state licensed nursing facility.

However, you don't have to receive skilled care to stay in a home that is licensed to give skilled care. **Missouri law** just requires nursing home licensing at the highest level of care. It is still possible to receive residential care in a skilled care facility.

Facilities licensed by the state as "residential care facilities," such as retirement homes, are not considered nursing homes because they do not provide regular nursing care. So your policy may not cover you in these types of facilities.

Before you purchase a policy, check to make sure that the type of care you may need someday is available in your community.

If you have a particular facility in mind, check to see if its services would be covered by your policy, particularly if you live in a rural area where skilled care facilities are not always available.

Your policy also will probably allow you to receive nursing care in another state, if you decide to move to be closer to a family member. However, you should check out this provision for every prospective policy.

WHAT IS NOT COVERED?

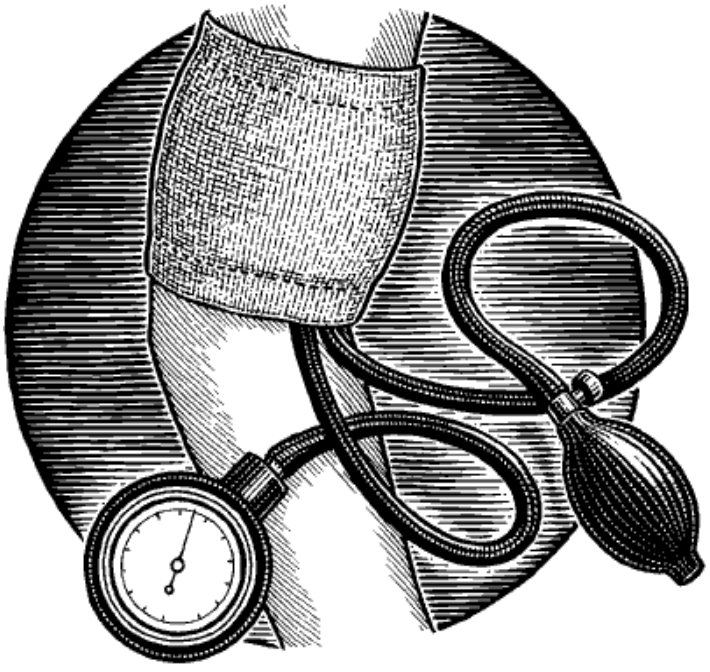
All policies contain some limitations and exclusions. Be sure to read the prospective policies carefully, and ask the agent for a full explanation.

PRE-EXISTING CONDITIONS

Insurance policies usually have a pre-existing condition clause in them. In general, if you have a health problem at the time you become insured, the company will not pay for treatment of that condition for a certain period of time.

The time period for the clause will vary depending upon the policy. However, companies commonly exclude coverage for care of pre-existing conditions for the first six months following the effective date of the policy.

For example, let's say you have been taking medication for *high blood pressure*. If you purchase a policy today, it may not cover long term confinements that relate to high blood pressure, such as a stroke or a heart attack, if they were to occur during the first six months you are insured.



However, if you needed to go into a nursing home because of a cancerous condition that developed after you bought the policy, then you would be covered.

If you have health problems, ask the agent exactly how your medical history would be treated under the policy. Be sure you understand what will and will not be covered. Some companies do not exclude pre-existing conditions. Others exclude them for less than six months.

Missouri does have a law about pre-existing conditions. Our law defines a pre-existing condition as a condition for which medical advice or treatment was recommended by or received from a health care provider **within six months before the effective date of your policy**.

In addition, the law states that if you decide to replace or convert your existing policy with a new policy, even if it's with the same company, a new waiting period for pre-existing conditions cannot be required. (For example, if you have satisfied four months of a six-month pre-existing conditions clause, you would have to satisfy only two months with the new policy.) However, if you decide to increase your benefits, you can be subject to a new waiting period for the increased benefits of the policy.

One last note: **it is extremely important that you fill out your insurance application correctly and completely when applying for coverage**. As you'll find out later in this booklet, the insurance company can deny you coverage just when you need it most, if you did not fill out your medical history properly.

SPECIFIC EXCLUSIONS

Before you buy, you need to make sure you understand what is not covered. Policies have different requirements that you may have to satisfy before benefits are payable.

In Missouri, all long term care policies that do have limitations must spell them out in an area that is clearly labeled "Limitations or Conditions on Eligibility for Benefits."

Long Term Care Plolicy Evaluation

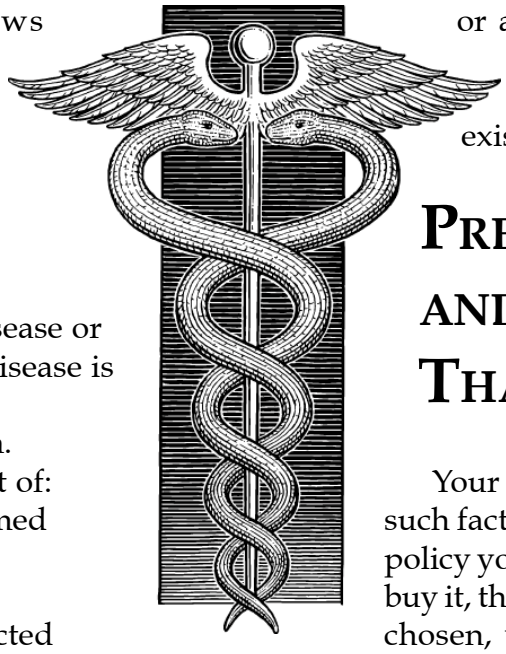
Use this checklist to compare policies.

	Policy A	Policy B
1. What services are covered?		
*Skilled Nursing Care		
*Intermediate Nursing Care		
*Custodial Care		
*Home Health Care		
*Adult Day Care		
*Other		
2. How much does this policy pay each day?		
*Skilled Nursing Care		
*Intermediate Nursing Care		
*Custodial Care		
*Home Health Care		
*Adult Day Care		
*Other		
3. How many years will benefits last?		
*Skilled Nursing Care		
*Intermediate Nursing Care		
*Custodial Care		
*Home Health Care		
4. Does the policy have a maximum lifetime benefit? If so, what is it?		

	Policy A	Policy B
5. Does the policy have a maximum length of coverage for each period of confinement? If so, what is it?		
6. How long is the waiting period before benefits begin?		
7. How long is the pre-existing conditions period?		
8. Do you have to keep paying premiums even while institutionalized? If so, for how long?		
*Nursing Home Care?		
*Home Health Care?		
9. Is prior care required before benefits begin?		
*A prior hospital stay before home health care?		
*A prior nursing home stay before home health care?		
10. Is there inflation protection?		
*What is the rate of increase?		
*Is it a simple or compounded interest rate?		
*How often is it applied?		
*Is there an additional cost?		
11. Is there a nonforfeiture clause that allows you to discontinue coverage but retain some benefits?		
12. What does the policy cost?		
Per month?		
Without inflation protection		
With inflation protection		
Per year?		
Without inflation protection		
With inflation protection		

LONG TERM CARE INSURANCE

In Missouri, our law allows insurance companies to limit long term care coverage or deny it for the following reasons:



1. Pre-existing conditions.
2. Mental or nervous disorders except those that are a result of a demonstrable organic disease or physical injury. Azheimer's disease is covered.
3. Alcoholism or drug addiction.
4. Injuries or illnesses as a result of:
   - A war or service in the armed forces.
   - A felony.
   - An intentionally self-inflected injury or an injury resulting from a suicide attempt while sane.
   - An aviation accident except when you are a paying passenger.
5. The company is not required to pay if the service is:
   - Provided by your immediate family.
   - Covered by Medicare or another governmental program (except Medicaid).
   - Provided in a governmental facility, unless otherwise required by law. Or you are required to pay in the absence of insurance.
   - Provided through a state or federal workers compensation program.

Prior Hospitalization

In Missouri, a policy can not require prior hospitalization before a nursing home stay.

On the other hand, it can require either a hospital or nursing home stay, before paying for home health care benefits. But, under Missouri law, the insurance company can not require more than 30 days of confinement before you qualify for home health benefits.

No policy can limit coverage, by using a rider or a waiver, for specific diseases or conditions beyond the six-month waiting period for pre-existing conditions.

Premium Cost and Factors That Affect It

Your premium cost will depend upon such factors as where you live, the type of policy you buy, how old you are when you buy it, the benefits it covers, the deductible chosen, whether you purchase inflation protection, and whether you retain value if you cancel your policy.

Let's look at some factors that contribute to the cost of your policy and your purchasing options.

Age

The cost of the coverage will depend on how old you are. Premiums are lower for younger people. But, the younger you are when you buy the coverage, the longer you will pay the premiums.

The premiums you pay for your policy generally remain the same each year; they will not increase as you grow older. However, there is one exception. Your premium can go up if the company increases the cost of the policy for all policyholders.

Benefits

Nursing Home Care

Premium costs are directly tied to the size of the daily benefit and the duration of benefits. For instance, a policy that pays $70 a day for nursing home care for up to three years will cost less than a

policy with lifetime benefits.

In Missouri, all indemnity policies are required to pay the designated benefit regardless of whether skilled, intermediate or residential care is received, in the nursing facility.

Home Health Care

Home health care typically pays smaller daily benefit amounts than nursing care because the services are less expensive.

In Missouri, home health care coverage may be applied to the in-home health care benefits provided in your policy to determine the maximum coverage available.

Ask your agent for detailed information about the benefits in your policy.

Duration of Benefits

Policies usually limit benefits to a maximum dollar amount or a maximum number of days. Often, separate benefit amounts are applied to nursing care and home health care within the same policy.

There are two ways a company may define a maximum benefit period. First, under a one-time maximum benefit period, if you bought a three-year policy, and stayed in a home for three years, it would never pay again in your lifetime.

Second, other policies offer a maximum benefit period for each "period of confinement." Under this definition, a three-year benefit period would cover more than one nursing home stay lasting up to three years if each of the stays were separated by six months or more.

Waiting Periods

A waiting period is the time it takes before your policy becomes effective. As previously stated in this brochure, waiting periods can be the length of time you have to wait because of a pre-existing condition clause or because your policy requires hospitalization prior to paying for home health benefits.

But your premium cost may also depend upon another type of waiting period. Some policies require that you pay for a specific number of days in a nursing home, or a specific number of home health visits, before benefits begin. You will have a choice in structuring your policy. If you buy a policy with a 20-day waiting period, your insurance benefits would begin paying for your stay on the 21st day.

Naturally, the longer the wait, the lower your premium.

Waiver of Premium

With some insurance policies, you have to continue paying premiums even if you are confined in a nursing home. Carefully check to see what types of restrictions are in your policy.

Inflation Protection

Because the cost of health care continues to rise, the policy you purchase today may be less useful tomorrow. Missouri law requires companies to offer inflation protection to all long term care purchasers. Evidence that the company offered this protection, and your response to the offer, must be in writing.

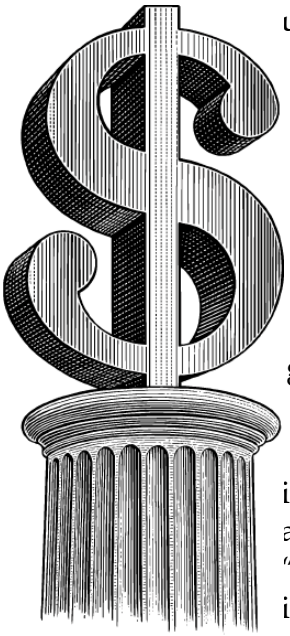
Life insurance policies that contain accelerated long term care benefits are not required to offer inflation protection.

Inflation protection is an option. Adding it to your policy will make it more expensive. It will also make it more useful.

Under Missouri law, your insurance company must offer you one of the following three options:

Option 1. Benefit levels must increase at a compounded rate of at least five percent a year.

Option 2. You can increase your benefit level periodically, without going through



underwriting again or without providing evidence of insurability or health status.

Option 3. Your policy will cover a specified percentage of actual or reasonable charges for each day you receive care rather than giving you a maximum specified amount or limit.

If you decide to buy inflation protection, ask your agent if the policy offers "simple" or "compounded" interest.

Compounded interest protects against inflation. Simple interest, while better than a daily benefit that remains constant, does not provide as much protection.

For example, the most common protection offered is 5 percent simple interest, which automatically raises your daily benefit limit by 5 percent each year. An $80 per day benefit would go up $4 a year. After 20 years, the $80 policy would have risen to $160.

Your benefits will increase faster and will more adequately keep up with inflation if interest is "compounded." At 5 percent compounded annually, the $80 policy would rise to $212 per day after 20 years.

Many consumers are reluctant to pay for policies that offer inflation protection, because the premiums cost more. But, if you buy the policy when you are in your 50s or 60s, an inflation protection rider is the only way to guarantee that the coverage will be adequate when you need it in 20 or 30 years.

Nonforfeiture Benefits

A nonforfeiture benefits clause is offered in some policies, usually employer-sponsored plans.

If you discontinue your coverage, or your coverage lapses because you forgot to pay the premium, this benefit returns part of what you have paid in premiums. The return will probably not be in cash, but will guarantee a portion of your benefits.

To receive a reduced benefit, you must pay premiums for a certain number of years. The policy should spell out this period and should state what portion of the benefit you will receive. For example, it might state, after 10 years of premiums, you will receive benefits at a level of 30 percent if coverage is discontinued.

Paid Up Premiums

Some companies offer a return of premium feature. At an additional cost, you can buy a policy that will return all or a portion of your premium depending upon whether you have claims. Generally, paid claims are deducted from the return of premium.

Favorable Tax Treatment

Federal tax laws were revised effective Jan. 1, 1997 to specifically address the tax treatment of unreimbursed long term care expenses as well as long term care insurance benefits and premiums.

The favorable tax treatment of long term care insurance premiums you pay and benefits you receive will only apply if the policy you buy is a qualified long term care policy, as defined by federal law. The insurer should state in writing whether the policy it proposes to issue you is a qualified long term care insurance policy.

Federal law now provides that unreimbursed expenses for qualified long term care services are treated as medical expenses for itemizing deductions (subject to the floor of 7.5 percent of adjusted gross income). Long term care insurance premiums also are treated as medical expenses for itemized deductions. This variable deduction increases with the age of the tax payer. The premium amounts are to be indexed to account for inflation.

Proceeds from a long-term care insurance contract are excluded from taxable income, subject to a cap of $175 per day, or $63,875 annually, on per-diem contracts. If the aggregate amount of periodic payments exceeds the cap, the excess payments are excluded from taxation only to the extent they represent actual costs for long term care services during the period.

Policy Renewals and Cancellations

Renewing Your Policy

Like all insurance products, your long term care policy can be cancelled if you do not pay your premiums.

However, Missouri law states that long term care policies cannot be cancelled or not renewed because of health, age or mental condition.

Look at the renewability provision of your policy, which is normally found on the first page. It will have the conditions for policy cancellations and premium increases.

Switching Your Policy

New policies in Missouri can no longer have requirements for a prior hospital stay or for prior levels of care. So, in many ways, new policies are more favorable to the consumer than older ones.

In addition, Missouri law states that your replacement policy may not contain new pre-existing conditions, waiting periods or probationary periods. If you have fully satisfied the waiting period under your present policy, your new policy can not require another waiting period. This law applies whether you purchase a new policy with your present company or a new policy with another company.

You should never switch policies before making sure the new policy is really better than the old one. Never discontinue your old policy until you know for sure that your new coverage has taken effect.

Cancellations

A company can cancel your policy even if you do pay your premiums, if you misrepresent your health status on your application. The company may also deny coverage when you file a claim. So, fill out your application completely and accurately.

Each policy sold in Missouri must have a cautionary note on misrepresentation when you sign the application, and when you receive the policy or certificate.

Free Look Period

Missouri law requires that insurance companies give you time to think over this important decision.

You have 30 days from the date you receive your policy to review it and decide whether to keep it. If within 30 days, you decide you are not satisfied for any reason, your entire premium must be refunded. The notice of the 30-day "free look" period must be printed prominently on your policy. The Missouri Department of Insurance urges you to use this time to review your policy and ask questions.

KNOW WHAT IS IN YOUR POLICY

Policies are confusing.

They are also legal contracts.

It's very important that you read your policy and understand the contents. Reading a sales or marketing brochure is not enough. Do not make a decision based solely upon insurance literature. Ask your agent for a sample policy. Then ask questions if you do not understand the provisions. Good agents and good companies want to make sure you understand what you are buying.

We also suggest you talk over this major decision with someone you trust, and ask them to look over the policy, too.

You also can get information about an insurance company's financial rating from the Missouri Department of Insurance. Several organizations rate insurance companies including A.M. Best, Standard and Poor's, and Moody's.

Consumer representatives with the Missouri Department of Insurance will not be able to advise you on whether you should buy a policy from a particular company. But they will discuss what your needs are and explain anything you don't understand. **The MDI consumer hotline number is 1-800-726-7390**.

CAN YOU AFFORD A LONG TERM POLICY?

Long term care is expensive. But so are the insurance premiums.

If your savings are low or modest, insurance may not be a good buy.

You need to ask yourself: Can I afford insurance? Do I have a level of assets worth protecting? If the premiums go up in the future, are my assets sufficient to pay the increase?

If you are 65, it's possible you may be paying premiums for 10 or 20 years before you need long term care. If the premiums are $1,200 a year, you will have paid $12,000 to $24,000 in premiums during that time even without inflation. Can you afford that?

ASSESSING YOUR INCOME

Many people who decide to purchase long term care insurance have assets they want to protect for their children. Or they want to preserve their independence and avoid relying on others.

Before shopping for a policy, sit down and list the income and assets you have available to pay for a nursing home stay. Include these items on your list:

Income

- Social Security income
- Private retirement or pension income
- Earnings from bank accounts, stocks, bonds, etc.
- Income from real estate rental
- Family contributions
- Veterans benefits

Assets you have available that you might sell or cash in:

- Savings accounts
- Certificates of deposit, money market

accounts

- Life insurance cash value
- Stocks, bonds, money market funds
- Real estate
- Personal property
- Antiques, jewelry

In general, if your total assets do not exceed the Medicaid guidelines on page 6, you do not need a long term care policy. You should not buy something you can not afford.

Individuals whose assets and normal cash flow are sufficient to pay for the cost of a nursing home stay may also choose not to purchase a long term care policy.

$HOPPING $UGGESTIONS

$ Your medical history is very important. Fill out the application truthfully and completely. Do not trust an agent who says your medical history is not important. If the health information on the application is wrong, the insurance company can refuse to pay your claims or cancel your policy. **If the agent fills out the medical information for you, look it over and make sure it is correct.**

$ Do not buy more than one long term care policy.

$ Carefully compare policies. They are not all the same. Check with several companies and several agents before buying.

$ Our state requires an agent to leave an outline of coverage at the time he or she initially contacts you. If an agent promises to provide the information later, we suggest that you do not deal with that person.

$ Be wary of an agent who says a policy can be offered only once. Do not let anyone scare you or pressure you into making a quick decision.

$ Ask the agent to come back a second time. Tell him or her you want a trusted friend or family member to hear the information before you purchase the policy. If the agent is not willing to come back again, do not purchase insurance from that agent.

$ If the agent gives you answers that are vague or that differ from the information in the policy or brochure, do not buy the insurance. Tell them you want to look over the policy.

$ Never, never, never pay the agent in cash. Always write a check payable to the insurance company.

$ Be sure to get the name, address and telephone number of the agent and the company he or she is representing.

$ Remember, if you purchase a policy, you do have a 30-day "free look" period. Be sure to review your policy, and make sure it covers the benefits you want.

FOR MORE INFORMATION

Additional information about health care coverage
and insurance is available from the following organizations:

FREE PUBLICATIONS

The Medicare Handbook

Guide to Health Insurance for People with Medicare
Publication No. HCFA-02110

Guide to Choosing a Nursing Home
Publication No. HCFA-02174

Available from:
U. S. Department of Health and Human Services
Health Care Financing Administration
6325 Security Boulevard
Baltimore, MD 21207

MORE INFORMATION

Division of Aging
Missouri Department of Social Services
615 Howerton Court
P.O. Box 1337
Jefferson City, MO 65102-1337

Aging Information Hotline Number:
1-800-235-5503

CLAIM Hotline
(Community Leaders Assisting the Insured of Missouri)
A private free counseling program for seniors.
505 Hobbs Road, Suite 100
Jefferson City, MO 65109
1-800-390-3330

Missouri Department of Insurance offices are listed on page 3.

GLOSSARY OF TERMS

ADULT DAY CARE - Care provided to persons in a community setting who cannot remain alone but do not require continual nursing care.

BENEFIT PERIOD - A specified amount of time for which benefits will be payable during confinement or period of illness.

COINSURANCE - A percentage of all expenses that an insured person is required to pay. For example, 20 percent of the "reasonable" charges under Medicare.

DEDUCTIBLE - This initial sum must be paid for services covered under an insurance plan before benefits are paid by the insurance company. Deductibles apply to Medicare but not to long term care policies.

DISCLOSURE FORM - A description of the benefits, exclusions and provisions in a policy.

EXCLUSION - A condition, circumstance or medical expense that the policy will not pay.

GUARANTEED RENEWABLE - The insurance company guarantees that the policy is renewable for life as long as the premiums are paid. The premiums can only increase if rates rise for all policyholders.

HOME HEALTH CARE - Medical and nonmedical services provided to ill, disabled or infirm persons in their residences. These services may include homemaker services such as assistance with preparing meals and cleaning the house. It may include assistance with activities of daily living such as eating, bathing, and taking medication. Respite care may be provided. Or, it may include medical assistance such as skilled nursing care or physical therapy. A physician's orders may be required to receive medical assistance.

INTERMEDIATE NURSING CARE - Medical care provided in a nursing facility to patients who require daily medical supervision, but not 24-hour care. The care is supervised by registered nurses and ordered by a doctor.

MEDICAID - A medical benefits program administered by the state and subsidized by the federal government. It provides health care services to those with low incomes or with very high medical bills relative to income and assets. Medicaid provides benefits for long term nursing home care once income and assets have been "spent down" to eligibility levels. It also provides home health and other non-institutional care.

LONG TERM CARE INSURANCE

MEDICARE - The federal program that provides persons who are disabled or 65 years and older with hospital and medical insurance. Medicare provides only limited benefits for nursing home services.

MEDICARE SUPPLEMENT INSURANCE - Also known as Medigap. This private insurance covers some costs not paid for by the federally funded Medicare program.

PRE-EXISTING CONDITION - A health condition that existed before the effective date of a policy. Many long term care policies have a waiting period of six months for pre-existing conditions.

PREMIUM - The dollar amount charged for an insurance policy.

RESIDENTIAL CARE - Care that is provided to someone who needs assistance with such daily living needs as eating, bathing, dressing, and taking medication. The care may be provided by nonmedical personnel.

RIDER - A document that is attached to your policy that changes the coverage you have in your policy. A rider may add coverage, remove coverage or redefine it.

SKILLED NURSING CARE - Care provided to patients on a 24-hour basis by skilled nurses based upon a physician's orders.

WAITING PERIOD - The time a policyholder must wait before receiving benefits.

WAIVER OF PREMIUM - A provision included in some policies that exempts the policyholder from paying premiums while receiving policy benefits.